

S. No. 1-8-43 5-17-39 I X37823

DEPARTMENT OF COMMERCE BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

223044

FILED AUG 9 1946 STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 9472

Primary Registration District No. 3013

Registrar's No. 63

1. PLACE OF DEATH: (a) County Clay (b) City or town. North Kansas City (c) Name of hospital or institution. St. Ann's Hospital (d) Length of stay: In hospital or institution. 3

2. USUAL RESIDENCE OF DECEASED: (a) State Mo (b) County De Kalb (c) City or town. Clarksville (d) Street No. (e) Citizen of foreign country? No

3. (a) PRINT FULL NAME WILLIAM CARVIN BUTLER (b) If veteran, name war (c) Social Security No.

20. DATE OF DEATH, Month July day 28 year 1946 hour 10:00 minute P.M. 21. I hereby certify that I attended the deceased from July 26 1946 to July 28 1946 that I last saw him alive on July 29 1946 and that death occurred on the date and hour stated above.

4. Sex male Color or race white (5) (6) (a) Single, widowed, married, divorced, single (b) Name of husband or wife (c) Age of husband or wife if alive years

Immediate cause of death. Asphyxia Due to Paralysis of muscles of Respiration Due to Acute Anterior Polio-myelitis 36 hrs

8. AGE: Years 19 Months 5 Days 16 (9) Birthplace Clarksville Mo (10) Usual occupation laborer

Other conditions. (Include pregnancy within 3 months of death) Major findings: Of operations Of autopsy 36

MOTHER FATHER { 12. Name Marion Butler 13. Birthplace Gentry Co Mo 14. Maiden name Alma Pearl Berchet 15. Birthplace Clarksville Mo 16. (a) Informant William Wilhelm (b) Address Clarksville Mo 17. (a) Burial, cremation, or removal (b) Date thereof 7-29-46 (c) Place: burial or cremation Clarksville 18. (a) Signature of funeral director John B. Brian (b) Address Mayville Mo 19. (a) Date received local registrar (b) Registrar's signature

22. If death was due to external causes, fill in the following: (a) Accident, suicide, or homicide (specify) (b) Date of occurrence (c) Where did injury occur? (d) Did injury occur in or about home, on farm, in industrial place, in public place? While at work? (c) Means of injury 23. Signature Dr. O. P. Hunt Date signed 7-29-46

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

X-

DISTRICT HEALTH OFFICER
Category No.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed *John G. Brown*
Licensed Embalmer No. *3953*
P. O. Address *Waysville, Pa.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. Aug638Registration District No. 12Primary Registration District No. 3013Registrar's No. 638

1. PLACE OF DEATH:

(a) County Clay
 (b) City or town North Kansas City
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
In ambulance
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community DeKalb Life
 years, months or days)

3. (a) PRINT
FULL NAMEWilliam C. Butler

3. (b) If veteran,

name war _____

3. (c) Social Security

No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married,
 divorced 5
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
 alive _____ years

7. Birth date of deceased July 12
 (Month) (Day) (Year)8. AGE: Years 19 Months 5 Days _____ If less than one day
 hr. _____ min. _____9. Birthplace Mo
 (City, town, or county) (State or foreign country)10. Usual occupation Teacher

11. Industry or business _____

12. Name Marion Butler13. Birthplace Mo
 (City, town, or county) (State or foreign country)14. Maiden name Vieme P. Becker15. Birthplace Mo
 (City, town, or county) (State or foreign country)16. (a) Informant Melton Wilhelm(b) Address Clarkdale17. (a) _____ (b) Date thereof 7-29-46
 (Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Clarkdale18. (a) Signature of funeral director John H. Bran(b) Address Marionville, Mo.19. (a) _____ (b) Beulah Kitchin
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County DeKalb
 (c) City or town Clarkdale
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 1946
 year 1946 hour _____ minute _____ M.21. I hereby certify that I attended the deceased from _____ to _____, 19____;
 that I last saw him _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.
 Immediate cause of death _____Due to AsphyxiaDue to Paralysis of muscles of RespirationDue to acute anterior PolomyelitisOther conditions _____
 (Include pregnancy within 3 months of death)Major findings:
 Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place)
 (e) Means of injury _____23. Signature Dr. W. R. Vandyke, London, Mo.
 Address Stewartsville, Mo.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

SUPPLEMENTARY

Duration

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

23044